THE DEPARTMENT OF VETERANS AFFAIRS

SUBSTANCE ABUSE TREATMENT SYSTEM:

Results of the 2003 Drug and Alcohol Program Survey

Department of Veterans Affairs

- **Program Evaluation and Resource Center**
- **HSR&D Center for Health Care Evaluation**

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Executive Summary

Background and Purpose: The Program Evaluation and Resource Center (PERC) conducts a triennial Drug and Alcohol Program Survey (DAPS) within The Department of Veterans Affairs (VA) health care system. This report presents results of the Fiscal Year 2003 (FY03) DAPS. At the end of FY03, the VA operated 215 substance abuse treatment programs, including 15 inpatient programs, 64 residential programs, 37 intensive outpatient programs, 98 standard outpatient programs, and 1 case-finding and early intervention team. These programs provided information on their settings, staffing, services, and patients. To assess trends within the system, FY03 results were compared with those from prior administrations of the DAPS.

Main Findings: Inpatient substance abuse treatment programs have been virtually eliminated within the VA health care system; the 15 identified in the FY03 DAPS represent a decline of 92% from the 180 of such programs that existed in FY94. The number of lower cost residential programs doubled from 32 in FY94 to 65 in FY00. This expansion partially offset the loss of about 3,000 inpatient substance abuse beds over the 1990s: However, the trend of expansion of residential beds ended in FY00, with FY03 marking the first documented loss in residential beds (89 beds) since the FY94 DAPS.

Overall, the number of intensive and standard outpatient programs (n = 135) at the end of FY03 was 15% lower than the 158 outpatient programs identified in the FY00 DAPS and 23% lower than the 176 outpatient programs identified in FY97 DAPS. The decline in outpatient services since FY00 resulted from a 49% decrease in the number of intensive outpatient programs (from 73 to 37 programs), which was only partially offset by a 13% increase in the number of less intensive standard outpatient programs (from 85 to 98 programs). This represents a reversal of significant growth in the scope and intensity of outpatient substance use disorder treatment services implemented by VA from FY91 through FY97.

Total staffing for substance abuse services (2,427 FTE) is now at approximately one half of the 4,718 employed in FY94. The reduction in substance abuse staffing noted from FY94 to FY00 slowed from FY00 to FY03, probably due to funding provided by the Veterans Millennium Health Care and Benefits Act of 2000.

While treatment intensity has decreased, the severity of problems in VA substance use disorder patients has increased from FY94 to FY03. In FY03, two-thirds of patients lacked a long-term intimate relationship. Further, the average program reported that half of their caseload had a co-morbid psychiatric diagnosis, compared to one-third of patients in FY94.

The number of veterans with substance use disorders increased by 31% (from 366,000 to 533,000) from FY00 to FY03 (McKellar, Lie, & Saweikis, 2004). The decline in the number of inpatient, residential, and intensive outpatient programs within the VA system has sharply increased the number of patients waiting for these services. From FY00 to FY03, the average number of veterans on waiting lists increased 458% at inpatient programs, 36% at residential treatment programs, and 100% at intensive outpatient programs. In contrast, standard outpatient

programs experienced a 42% decrease in the number of patients waiting for services. Fewer programs and longer wait times has led to fewer patients being treated per year. In FY03, the average number of annual admissions per program declined 18% at inpatient programs, 4% at residential programs, and 18% at intensive outpatient programs, while the average number of annual admissions per program increased 6% at standard outpatient programs. Overall, the average number of veterans treated per VA substance abuse treatment program decreased 8% from FY00 to FY03.

Among veterans who received treatment for substance use disorders, there was only one major change from FY00 to FY03 in terms of the type and scope of treatment services provided. Availability of opioid agonist treatment (OAT) in the VA system has increased substantially in the last three years. However, a significant proportion of patients dependent on opiates are still not receiving this highly effective treatment.

The availability of substance use disorder treatment services offered to veterans across VA Integrated Service Networks (VISNs) remained variable in FY03. In FY00, two networks had no inpatient or residential programs. In FY03, every VISN had at least 1 inpatient or residential treatment program and at least 1 intensive or standard outpatient program. However, the number of programs available still varies substantially across VISNs, from a minimum of 3 programs in VISN 17 to a maximum of 18 programs in VISN 1.

Conclusions: Since FY94, the problems of VA patients with substance use disorder have increased while the services available to them have decreased. From FY00 to FY03, the number of inpatient, residential and intensive outpatient programs decreased amidst a modest increase of less intensive standard outpatient programs. The loss of programs offering more intensive services was accompanied by a decrease in the number of patients being treated at the remaining programs and an increase in the length of time patients wait to be treated.

It appears that the Veterans Millennium Health Care and Benefits Act of 2000 (P.L. 106-117), which allocated $9.5M for substance abuse treatment, expanded capacity for some patients; however, a substantial proportion of these gains in treatment capacity were offset by reductions in other substance use disorder programming. Analysis of the DAPS data highlights the need to support the maintenance of currently available treatment services while expanding new substance use disorder treatment services in order to produce significant gains in treatment capacity.

Introduction

This report summarizes and analyzes the results of the Program Evaluation and Resource Center's (PERC) survey of the 215 substance abuse treatment programs operated by the Department of Veterans Affairs (VA) in Fiscal Year 2003 (FY03). Under the auspices of the VA Mental Health Strategic Healthcare Group, PERC conducts policy-relevant evaluations of the content, structure, and effectiveness of VA programs. This report describes PERC's FY03 Drug and Alcohol Program Survey (DAPS), and compares its results to those of prior years. This report is used to inform program managers, clinical staff, network directors, and policymakers about the status of the VA substance abuse treatment system.

The 2003 DAPS (see Appendix) assessed program structure, staffing, process of care, and treatment services. The 215 programs participating[1] in the 2003 DAPS were all VA programs that (1) were specifically designed to provide treatment for patients with substance use disorders (SUD), (2) had at least two full-time equivalent (FTE) staff members, and (3) could be distinguished from other programs because they had unique staffing, patients, clinical services, and/or policies. As in prior years, programs for substance dependent patients who also had a co-morbid psychiatric disorder (e.g., "dual diagnosis" programs) were included in the DAPS.

Analysis of the 2003 DAPS data is organized around the four main types of substance abuse treatment programs[2] in the VA:

Inpatient programs provide acute, in-hospital care and may provide detoxification and stabilization services as well. Inpatient programs are typically designed to treat patients for 14 to 28 days. In FY03, the VA operated 15 inpatient substance abuse programs, all but one of which also offered outpatient/aftercare services.

Residential programs are based in domiciliaries and in on- and off-site residential rehabilitation centers. They are distinguished from inpatient programs by being less medicalized, having lower staffing levels, and longer lengths of stay. In FY03, the VA operated 64 residential substance abuse programs, about half of which (33 programs, or 52%) also offered outpatient/aftercare services.

Intensive outpatient programs provide more than four hours of services per day of treatment to VA substance abuse outpatients. This category comprises day treatment, partial hospital, and intensive outpatient clinic-based programs. In FY03, the VA operated 37 intensive outpatient programs, 33 (89%) of which were designed to treat patients 5 days a week or more.

Standard outpatient programs are clinics that provide less intensive ambulatory addiction treatment services. The VA operated 98 standard outpatient programs in FY03, most of these programs (67 programs, or 68%) were designed to treat patients 1 to 3 days per week.

This report is organized as follows: First, we provide an overview of program settings, structure, staffing and patients in the VA's national system of substance abuse treatment, noting

how the system has changed over the past decade. Next, we describe the content of VA substance abuse treatment programs, including their accessibility and services. Finally, we describe addiction services from the perspective of each of the VA's 21 Networks, and make recommendations to strengthen the VA's substance abuse treatment system.

Program, Staff and Patient Characteristics

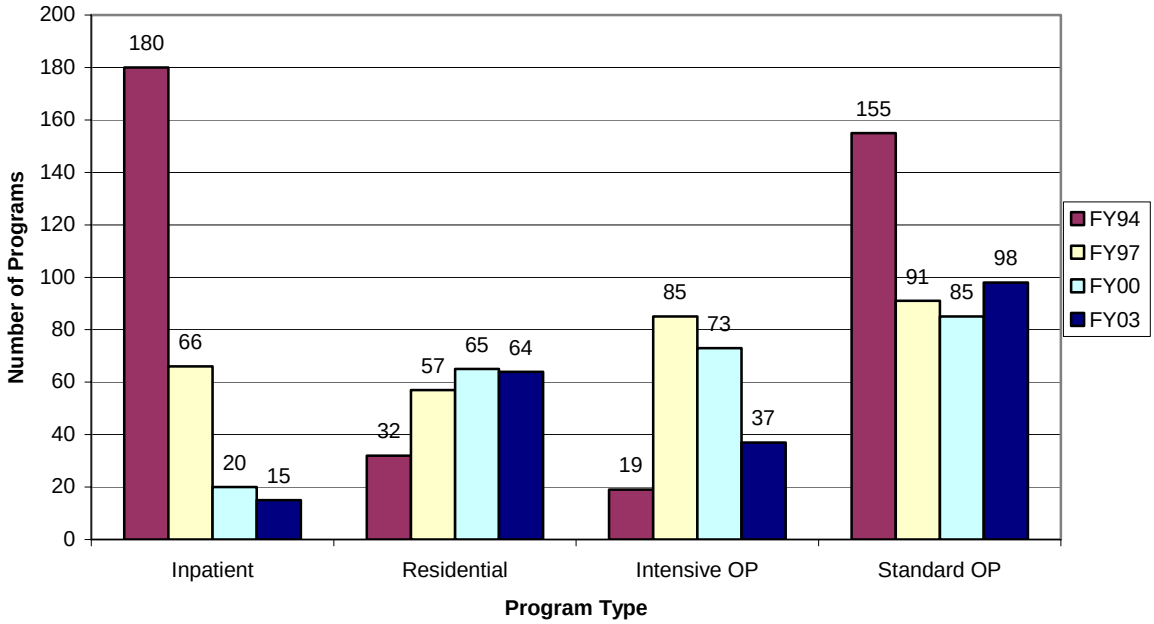
Overall Profile of the System, 1994-2003

The triennial DAPS survey has shown a consistent decline in the total number of VA substance abuse treatment programs since FY94. Overall, the number of VA substance abuse treatment programs has decreased by 45%, from 389 to 215 programs, over the last 9 years. Specifically, the number of programs decreased by 22%, from 389 to 304 programs, over the course of FY94 to FY97 (Humphreys, Hamilton, & Moos, 1996; Humphreys, Dearmin, Huebsch, & Moos, 1998). This decline was then followed by a further 19% decrease in programs (from 304 to 246) from FY97 to FY00 (Humphreys & Horst, 2001). Over the last three years (FY00 to FY03), VA substance abuse treatment programs have experienced a further reduction of 13%, from 246 to 215 programs. This reduction may be responsible for an overall decrease in the number of veterans receiving specialized SUD treatment services from FY00 to FY03; even as the number of veterans with SUDs increased steadily over this same time period (McKeller, Lie, & Saweikis, 2004). Specifically, about 101,000 veterans received specialized SUD treatment services in FY00, while only 88,000 veterans received specialized SUD treatment services in FY03. An increase in the number of veterans diagnosed with SUDs (from 366,000 to 533,000) occurred concomitantly.

As shown in Figure 1, the majority of the contraction observed from FY00 to FY03 can be attributed to the 49% decline in intensive outpatient programs, from 73 to 37 programs. The decline in intensive outpatient programs was an acceleration of a trend evident since FY97. Since FY97, intensive outpatient programs have decreased by 56%, from 85 to 37 programs. In contrast, from FY00 to FY03, standard outpatient programs expanded by 13%, from 85 to 98 programs, reversing the trend of standard outpatient contraction observed since FY94. Because intensive outpatient programs provide more hours of service than do standard outpatient programs, a small increase in standard outpatient programming concurrent with a large decline in intensive outpatient programming represents an overall decrease in the amount of outpatient services provided to veterans with substance use disorders (SUDs).

A decrease in the already much reduced number of inpatient programs available to veterans is evident from FY00 to FY03. Specifically, the number of inpatient programs has decreased by 25%, from 20 to 15 programs. Inpatient programs have been closing across VA since FY94, when there were 180 inpatient programs. The number of inpatient programs has now been reduced to 15, a 92% decrease since the end of FY94.

Figure 1: Number of VA Substance Abuse Treatment Programs, FY94 - FY03



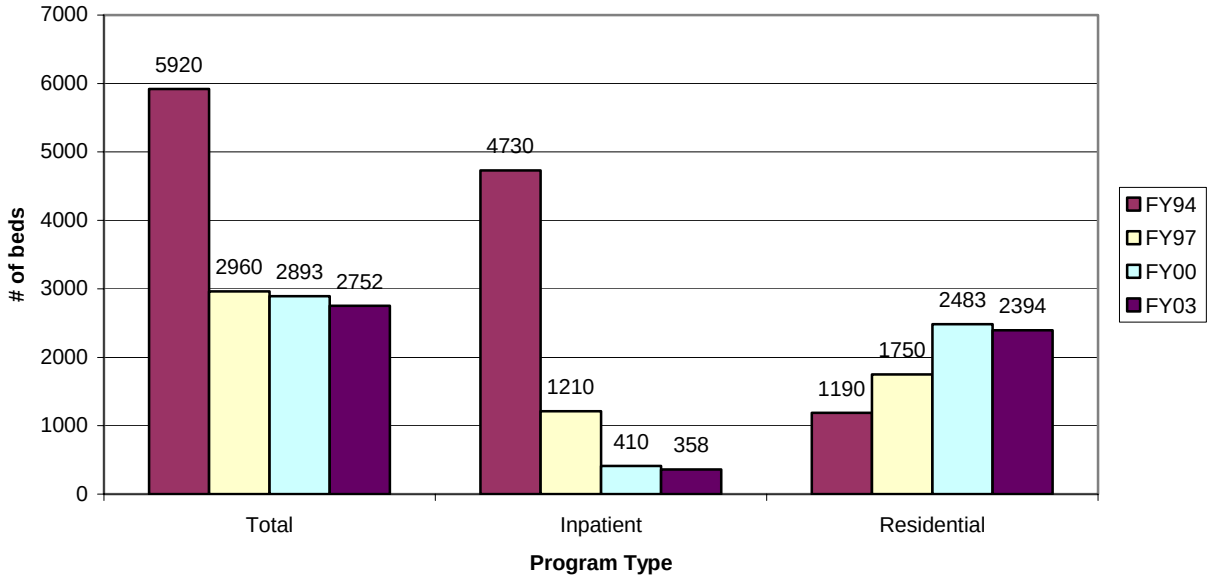
As Table 5 shows, only 11 of the 21 VISNs (52%) have an inpatient treatment program, rendering this form of addiction treatment almost extinct. Viewed together, the inpatient and outpatient data indicate that policy trends evident when the FY00 DAPS was conducted (Humphreys, & Horst, 2001) continued through FY03. These changes originated in FY95 when the system was decentralized and VA facilities were given the mandate to shift their emphasis from inpatient to outpatient services (Kizer, 1996; Humphreys, Dearmin, Huebsch, Moos, & Suchinsky, 1999). One indication of the sustained and significant nature of this shift is that while the number outpatient programs in FY94 was approximately equal to the number of inpatient programs, by FY03 there were 9 outpatient programs for every inpatient program. This results in a system representative of the nation's public and private substance abuse treatment system, in which 90% of services are provided on an outpatient basis (SAMHSA, 2000).

With the decrease in inpatient treatment beds, one might hope that lower cost residential treatment programs would proliferate to counteract the loss. By the close of FY00, inpatient substance abuse treatment beds were almost eliminated at VA facilities, but this was partially offset by a more than doubling of the number of residential beds from FY94 to FY00 (Humphreys & Horst, 2002). Unfortunately, residential programs have not continued to expand from FY00 to FY03; in fact, the number of programs has decreased by one, marking the first time that residential beds have failed to increase in number since the FY94 DAPS. Moreover, the loss of residential beds from FY00 to FY03 coincided with the continued loss of inpatient beds from FY00 to FY03 (see Figure 2). From FY00 to FY03, VA lost 52 inpatient beds and 89 residential beds. This is an overall decrease of 141 beds since FY00 and a loss of 3,168 beds

since FY94, resulting in a system that offers 54% fewer beds to its patients than did the former system.

The decline in available inpatient and residential beds has led substance use disorder treatment providers to seek alternate housing arrangements for the many treatment seeking veterans who are homeless or live distant from an outpatient treatment program. Intensive outpatient programs reported that only 23% of their patients stayed in private residences while they were receiving treatment. Overall, 45% of outpatients stayed in on-site VA facilities, such as domiciliaries, during treatment, with another 17% of patients staying in community-based facilities owned or contracted by the VA. Another 13% were housed in non-VA affiliated community facilities. In contrast to intensive outpatient programs, standard outpatient programs caseloads were largely (64%) composed of patients staying in a private residence during treatment. Only 10% of standard outpatients stayed in on-site VA facilities and only 13% stayed in community-based VA facilities. Another 12% stayed in non-VA community-based facilities. The fact that intensive outpatient programs house 62% of their patients in VA funded facilities during treatment suggests that the need for beds for substance use disorder patients remains and that intensive outpatient programs have made substantial efforts to provide housing options within the VA system to their patients. On the other hand, standard outpatient programs would appear to predominantly treat patients who can provide for their own housing. Thus, the shift from intensive outpatient to standard outpatient programming seen between FY00 and FY03 may have reduced access to care for patients requiring housing during their treatment (e.g. homeless or rural populations).

Figure 2: Number of Beds in Inpatient and Residential Programs, FY94 - FY03



Staffing

Changes in substance abuse staffing mirrored the aforementioned programmatic changes. The total number of FTE in the system in FY03 was 2,427, down from 2,471 in FY00. The modest decline in staff (2%) observed in FY03 represents a deceleration of a trend evident since FY94 and is probably the result of funding for additional substance abuse staff provided by the Veterans Millennium Health Care and Benefits Act of 2000. The number of VA substance abuse staff peaked in FY94 at approximately 5,000 FTE, many of them hired through the VA's $100M substance abuse enhancement initiative (Greenbaum, Swindle, & Moos, 1993; Humphreys, Hamilton, Moos, & Suchinsky, 1997). The number of staff in the system has been declining since that point and total staffing for substance abuse services (2,427) is now at approximately one half of that employed in FY94 (4,718).

Figure 3 breaks down staffing changes by program type. Consistent with changes in program numbers, from FY00 to FY03, there was a decrease in FTE in inpatient (12%) and intensive outpatient (41%) programs, and an increase in FTE in standard outpatient programs (27%). Despite losing one residential program, the total number of FTE in residential programs increased slightly (1%).

Average FTE per program increased slightly across program types from FY00 to FY03 (average FTE = 12 and 13.6, respectively). Inpatient programs still employ the largest staffs, with an average of 22.7 FTE per program. Residential programs maintained staffing at levels similar to FY00, with an average of 13.1 staff per program. Both intensive outpatient and standard outpatient programs grew somewhat to 9.6 FTE and 8.8 FTE respectively.

Figure 3: FTE Staff by Program Type, FY94-FY03

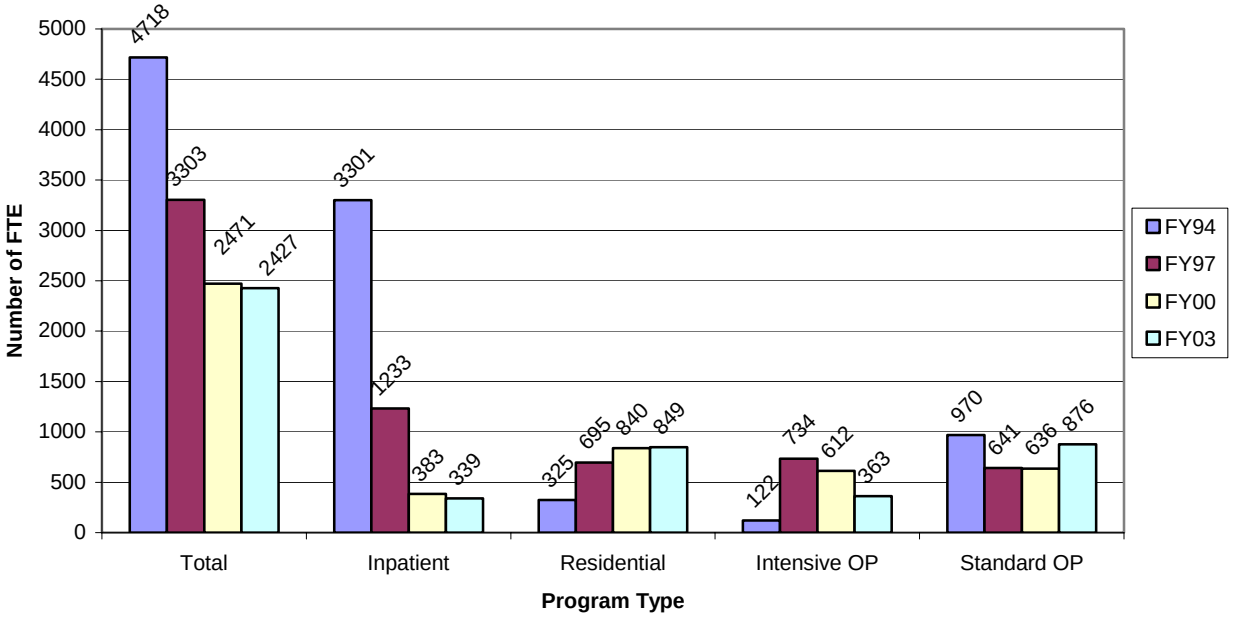


Table 1 demonstrates the diversity of professional staff employed by VA substance use disorder treatment programs. Psychiatrists represent 4-8% of staff across program types; psychologists are similarly represented. Non-psychiatrist physicians are the least common type of staff employed across programs types, representing only 1% of staff. On the other hand, nursing professionals (e.g., Registered Nurses, Clinical Nurse Specialists) are the most common type of staff employed across programs types. Addiction therapists and social workers are also well represented across programs types.

Table 1: Staffing in VA Programs by Position (% of FTE)

Position	Inpatient	Residential	Intensive OP	Standard OP
Psychiatrist	7	4	8	8
Physician	1	1	1	1
Psychologist	6	6	7	8
RN/NA*	35	29	24	19
Social Worker	9	10	15	15
Addiction Therapist/Counselor	19	20	23	26
Technician/Aide	4	8	4	3
Pharmacist	1	1	1	2
Recreational Therapist	1	3	2	2
Vocational Rehab. Specialized	1	3	2	2
Secretary/Clerk	8	8	9	11
Other Staff	8	7	4	3
Total	100	100	100	100

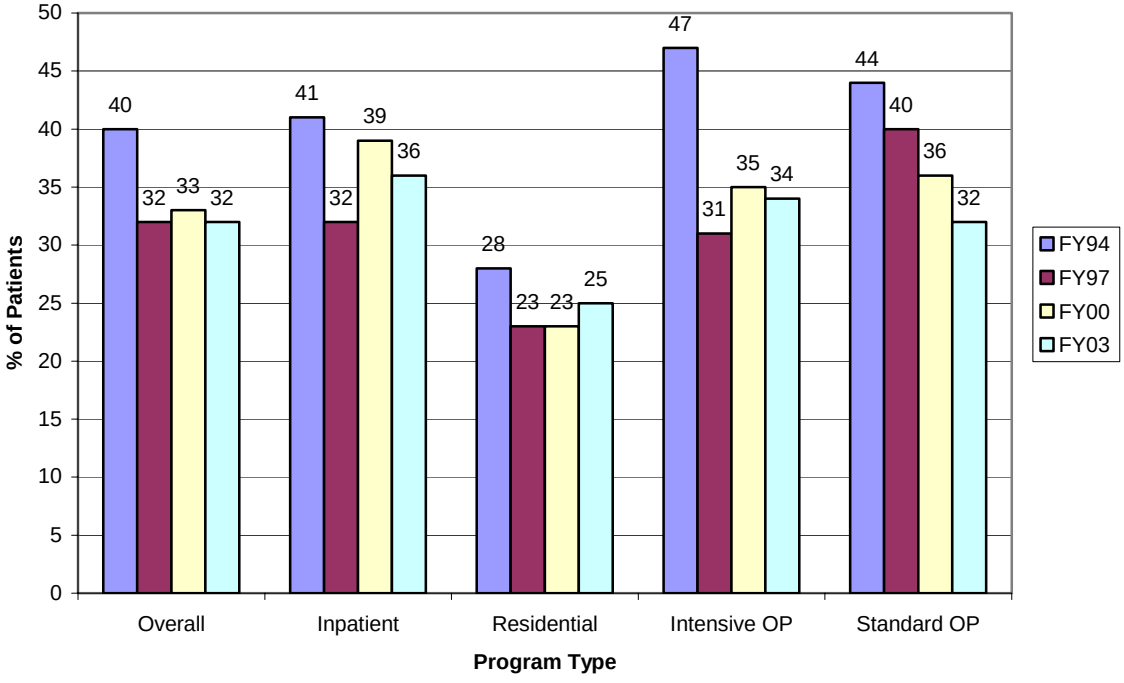
*This category includes RN, NA, Phys. Asst., LPN, LVN, and Clinical Nurse Specialist

The traditional differences in staffing patterns between inpatient and residential treatment programs have become less pronounced in the last 3 years. There has been a decline in non-physician medical staff at inpatient programs, the percentage of staff in the RN/NA category decreased from 49% in FY00 to 35% in FY03, and the percentage of staff that are addiction therapists increased from 11% in FY00 to 19% in FY03. This suggests that treatment offered at inpatient and residential programs may have become more similar in content.

Patients

Since the FY00 DAPS, PERC has gathered minimal data on patient characteristics because such data are now gathered through the nominal Addiction Severity Index (ASI) administration program (Poon, Weingardt, & Humphreys, 2003; Moos, Finney, & Suchinsky, 2000). In order to supplement the picture provided by the ASI program, the DAPS has consistently gathered information on the percent of patients who are married (or living in a long-term, marriage-like relationship) and the percent of patients who have a serious co-morbid psychiatric disorder. Both being unmarried and having a psychiatric diagnosis predict worse outcome in substance abuse treatment (Lemke & Moos, 2002; Stoffelmayr et al., 1989); therefore, the data presented in Figure 4 and Figure 5 provide an idea as to how VA substance abuse patients are changing on important prognostic dimensions over time.

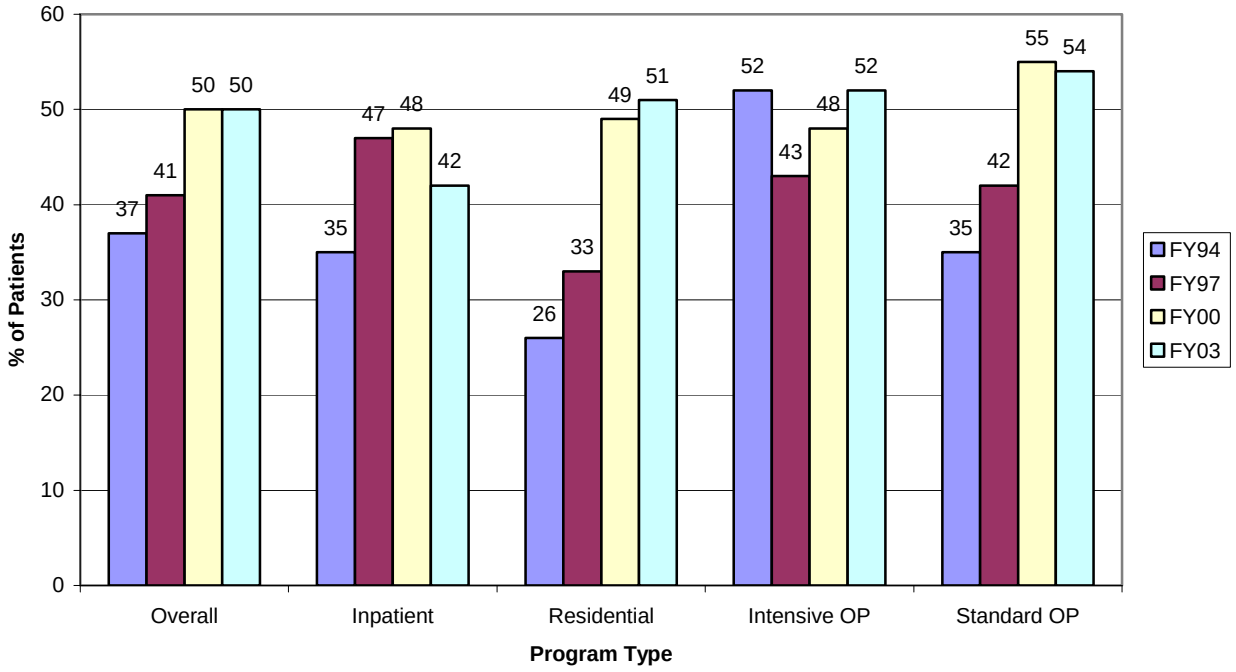
Figure 4: Average Percent of VA Substance Abuse Patients who are Married or in a Marriage-Like Relationship, FY94-FY03



As shown in Figure 4, the proportion of patients who are married or in a marriage-like relationship changed little from FY00 to FY03, after a large decline since FY94. Although the number of patients who are married or in a marriage-like relationship has increased in residential programs from FY00 to FY03, these programs continue to attract patients who are less socially stable relative to patients in other VA substance abuse treatment settings.

With regard to the proportion of patients with serious co-morbid psychiatric disorders by treatment setting, the data show mixed results. From FY00 to FY03, individual program types show small changes in contrary directions, suggesting little change in the system as a whole. However, co-morbidity prevalence remains high in absolute terms, and is clearly a more pressing concern than it was at the end of FY94. In terms of co-occurring disorders: 67% of inpatient programs, 51% of residential programs, 39% of intensive outpatient programs, and 53% of standard outpatient programs responded that they were capable of treating patients with serious co-morbidities within their programs.

Figure 5: Average Percent of VA Substance Abuse Patients with a Psychiatric Diagnosis, FY94-FY03



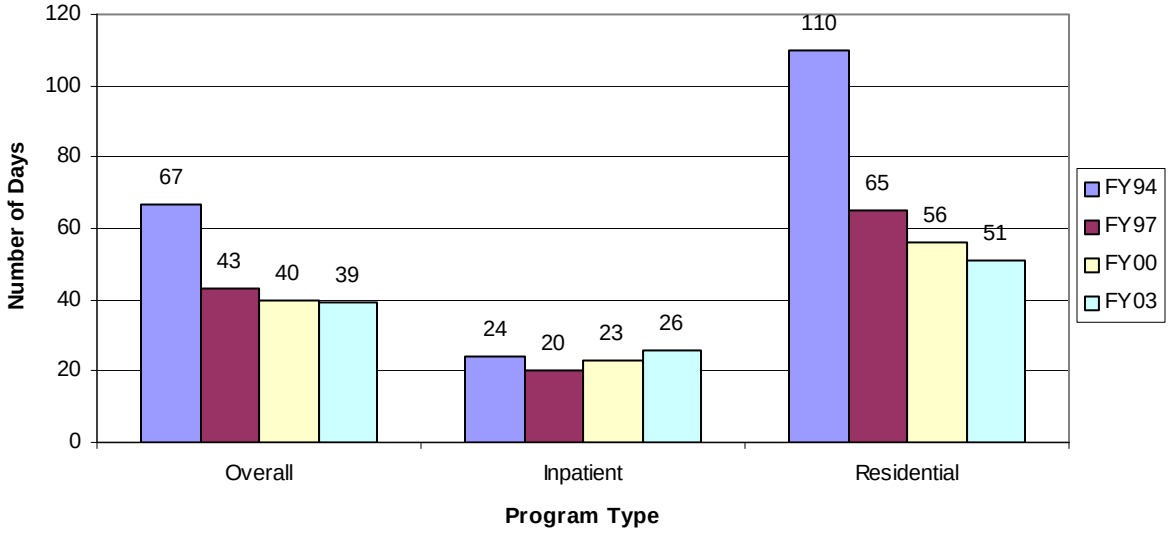
The Content of Treatment

Program structure and accessibility

For patients to benefit from treatment, they must be able to gain access to services. For that reason, in FY94 the DAPS began tracking the length of program waiting lists.[3] For programs that maintained waitlists, the length of the waitlists changed in a manner consistent with the change in availability of programs from FY00 to FY03. The decline in number of inpatient, residential, and intensive outpatient programs in the system coincided with an increase in the number of patients on waitlists at these programs. From FY00 to FY03, the average number of patients on waiting lists increased 458% (from 12 patients to 67 patients) at inpatient programs, 36% (from 14 to 19 patients) at residential programs and 100% (from 11 patients to 22 patients) at intensive outpatient programs. In contrast, the increase in the number of standard outpatient programs coincided with a 42% decrease in the number of patients on waiting lists at these sites, from an average of 19 patients in FY00 to an average of 11 patients in FY03.

In FY03, the average number of annual admissions per program decreased 18% at inpatient programs (427 in FY00, 352 in FY03), decreased 4% at residential programs (258 in FY00, 247 in FY03), and decreased 18% at intensive outpatient programs (525 in FY00, 431 in FY03); whereas, the average number of annual admissions per program increased 6% at standard outpatient programs (604 in FY00, 638 in FY03). Taken together, the average number of annual admissions per program decreased 8% (1814 in FY00, 1668 in FY03) from FY00 to FY03. Thus, the loss of inpatient, residential, and intensive outpatient programs amidst an increase in less intensive standard outpatient programs represents a shift from high intensity treatment options to lower intensity treatment options; moreover, the loss of programs coincides with an overall reduction in the number of veterans being treated at remaining SUD treatment programs.

Figure 6: Average Length of Stay for Inpatient and Residential Programs, FY94-FY03



Treatment Guidelines and Treatment Activities

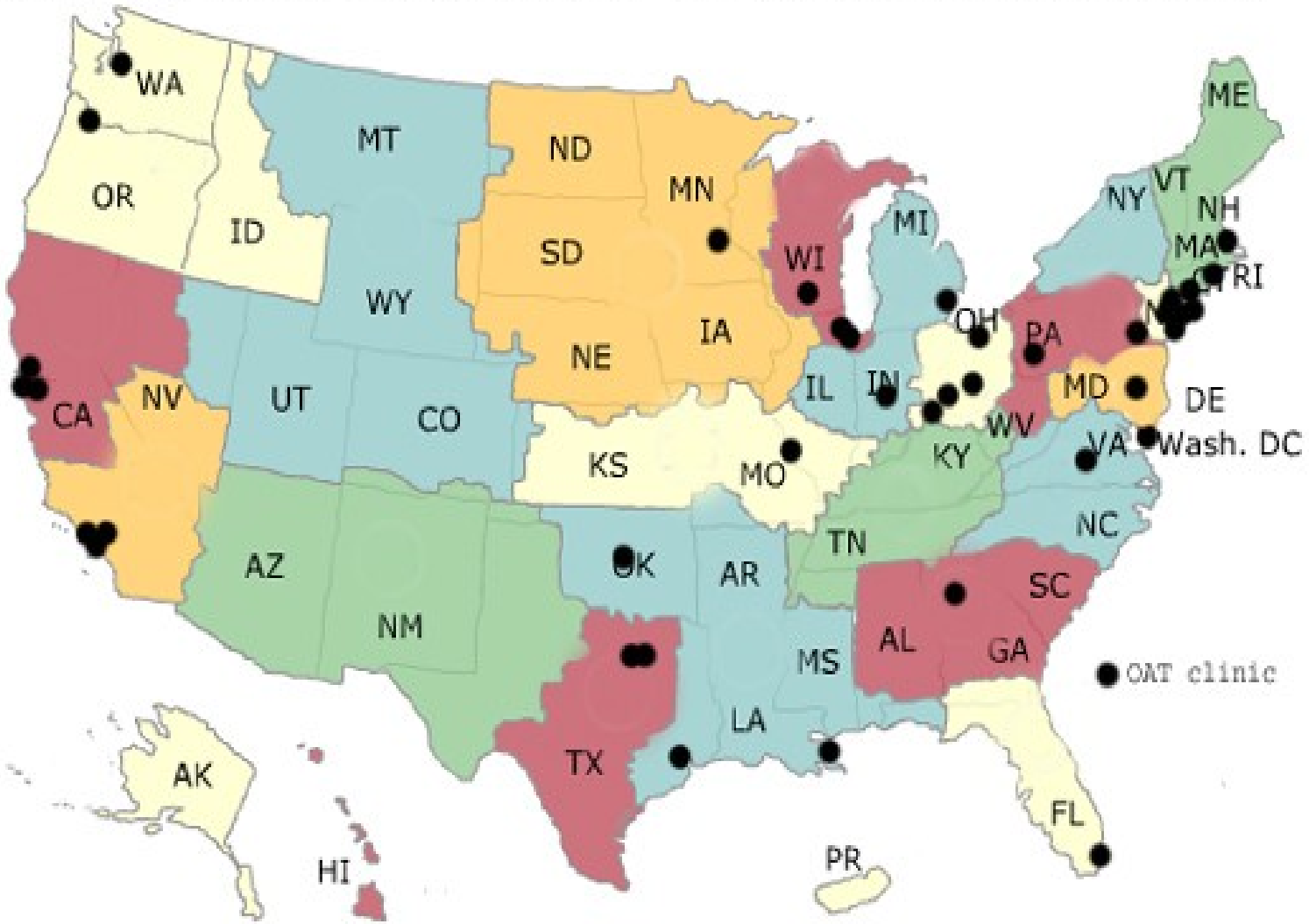
Clinical practice guidelines are an important development in addiction medicine. Such guidelines help providers make empirically supported decisions about treatment. In FY03, 80% of program managers reported that they usually based treatment decisions on clinical practice guidelines, comparable to FY00 (79%), but a significant increase from FY97 (64% of program managers). The increase from FY00 was likely due to the development of draft VA-based guidelines, which are relied upon most commonly (75% of those using guidelines). The other most relied-upon set of guidelines are those of the American Society of Addiction Medicine (56%). Use of these guidelines is comparable to that of private sector providers, 68% of whom rely on ASAM criteria (Roman & Blum, 1997). Why 20% of providers continue to not use guidelines is unknown, but may betoken a need for increased continuing education in this area.

Once in treatment, patients may receive medications, psychosocial services, or both. Of medications, opioid agonists (e.g., methadone) deserve detailed attention. In opioid agonist treatment (OAT), such medications are provided along with supportive psychosocial services. OAT has a strong record of effectiveness and was chosen by the VA Quality Enhancement Research Initiative Substance Use Disorder Module as a major focus for treatment improvement efforts (QUERI Substance Use Disorder Module and Executive Committee, 2000). A recent study of effectiveness found that 67% of opiate-dependent veterans that entered VA OAT programs reported abstinence from heroin after 1 year (Humphreys, Trafton and Barnett, 2003). With the support of Congress, VA leadership, and QUERI researchers, availability of OAT in the VA system has increased substantially in the last three years. The average percentage of outpatient caseloads receiving OAT has more than doubled from 8% in FY00 to 17% in FY03 (Table 2). A significant portion of patients are dependent on opiates in all program types, and therefore are candidates for OAT. Despite recent expansion in OAT, a large quantity of patients do not receive this highly effective treatment. Figure 7 shows that the availability of OAT offered to veterans is sparse; many states are without a single OAT clinic.

Table 2: Average Percent of Patients Opiate Dependent and Receiving Opiate Agonist Treatment

Table 2	Inpatient	Residential	Intensive OP	Standard OP
% Opiate dependent	13	17	18	25
% Receiving long-term opiate agonist treatment (OAT)	8	2	6	17
% Receiving medication to aid detoxification from opiates	13	3	5	3
% Receiving naltrexone for opioid use	2	1	1	1

Figure 7: Opiate Agonist Treatment in the Veterans Health Administration



Reflecting the large proportion of substance use disorder patients with a co-morbid psychiatric disorder, roughly 40% of substance use disorder patients receive pharmacotherapy for psychiatric problems (Table 3). The fact that the percentage of patients receiving medication for psychiatric problems is only slightly lower than the percentage of patients reported to have a co-morbid psychiatric disorder suggests that VA substance use disorder treatment staff are responsive to patients' needs for pharmacotherapies for psychiatric disorders. However, overall rates of prescribing of medications recommended for the treatment of substance use disorder remain low. Despite a high (1-A) rating supporting the use of naltrexone for the treatment of alcohol use disorder in the VHA/DOD practice guideline, naltrexone is infrequently prescribed for this purpose. Naltrexone treatment is used far less frequently than medications to aid detoxification from alcohol (e.g., benzodiazapines), even though naltrexone treatment is indicated for a much broader range of alcohol use disorders than medications for detoxification (i.e. used only in severely dependent drinkers). Encouragingly, prescription of smoking cessation aids has increased since FY97, up from 10% of patients in inpatient settings, and 5% of patients in all other settings in that year. As up to 90% of the VA SUD patient population smoke, the increases in smoking cessation treatment are encouraging.

Table 3: Average Percent of Patients Receiving Pharmacotherapy

Treatment	Inpatient	Residential	Intensive Outpatient	Standard Outpatient
Medications for psychiatric problems	38	56	39	42
Medication to aid detoxification from alcohol	19	6	10	7
Naltrexone for alcoholism	5	2	2	4
Smoking cessation aids	27	16	9	12

Turning to psychosocial services, Table 4 provides data on four service domains drawn from the Addiction Severity Index (McLellan, Luborsky, Woody, & O'Brien, 1980): Substance abuse, psychiatric, medical, and employment/support. Across program types, substance abuse-related group and individual psychotherapy is provided to almost all VA patients. Most patients in residential programs, and about half of patients in inpatient and intensive outpatient programs participate in on-site substance abuse-related self-help groups, such as Alcoholics Anonymous. As in FY00, a significant minority of patients in outpatient settings (18%) participate in on-site substance abuse-related self-help groups. Additionally, small minorities of patients (8%) receive contingency contracting as a means of reinforcing important treatment outcomes.

Comparable to FY00, in all program types, the majority of VA substance abuse patients receive a psychiatric assessment, and almost half receive psychotherapy specifically focused on psychiatric problems. Only 9% of patients receive couples or family psychotherapy, despite the facts that 32% of patients are married and couples therapies for addiction generally have excellent outcomes (McCrady, Hayaki, Epstein, & Hirsch, 2002; O'Farrell, Choquette, & Cutter, 1998). The small proportion of programs offering couples or family therapy may reflect the social isolation of many VA patients, or a lack of training and resources to provide these therapies.

Most VA substance abuse treatment programs (74%) are now screening patients for Hepatitis. Identification of these persons through testing has become a high priority for VA, and the system should continue to make progress towards universal screening of SUD patients. Substance abuse treatment programs may be particularly effective in reaching veterans who have Hepatitis C because many substance users have injected drugs and are therefore at a higher risk for infectious disease.

As expected, employment and support services are provided most commonly in residential programs. Close to half of patients in residential programs receive vocational/educational counseling and about a third receive vocational rehabilitation or some form of work training.

Table 4: Average Percent of Patients Participating in Treatment Activities

Treatment Activity	Inpatient	Residential	Intensive Outpatient	Standard Outpatient
Substance Abuse Services:				
Substance abuse-related group or individual psychotherapy	98	94	88	87
Substance abuse-related self-help groups	45	80	48	18
Contingency contracting	4	6	11	11
Woman specific groups or services	6	7	1	1
Psychiatric and Family/Social Services:				
Psychological/Psychiatric assessment	75	67	61	65
Group or individual therapy related to psychiatric problems	52	48	34	31
Couples or family psychotherapy	12	8	11	5
Medical Services:				
Hepatitis screening	82	77	76	59
Employment/Support Services:				
Vocational rehabilitation or work training	16	30	11	8
Vocational/Education counseling	29	47	37	9

The structure of care across VA Networks

The VHA comprises 21 Veterans Integrated Service Networks (VISNs), each of which has considerable discretion in deciding how to structure health care for its covered population. In FY00, two networks had no inpatient or residential programs. Encouragingly, despite the declines in program number and staffing across the VA in FY03, all VISNs provide at least some specialty substance use disorder services.

The number of programs available still varies substantially across VISNs with a minimum of 3 programs in VISN 17 to a maximum of 18 programs in VISN 1 (see Table 5). Further, 7 networks have 6 or more outpatient programs whereas 11 networks have 3 or fewer such programs. When VA substance abuse services are less readily available, patients with substance use disorders may make greater use of costly psychiatric and medical services (Humphreys et al., 1997), so we cannot be sure whether networks with fewer services expend more or less fiscal resources on veterans who have drug and alcohol use disorders.

Figures 8 and 9 show the number and type of VA substance abuse treatment programs by VISN from FY94-FY03. In FY03, all VISNs have fewer programs than in FY94. From FY00-FY03, only 24% of VISNs (5 of 21) gained any specialized substance abuse treatment programs. The majority of VISNs either lost programs or maintained their overall number of programs.

The proportion of patients on waiting lists to available beds provides an informative measure of supply and demand for substance use disorder treatment in each network. As shown on Table 6, there is substantial variation across networks with regard to the number of patients on waiting lists. For example, within 4 networks, the waiting list for inpatient substance abuse treatment exceeds the total capacity of the network, whereas 6 other networks are providing inpatient treatment on demand. Turning to residential treatment, only 4 of the 19 Networks with residential programs (21%) have residential beds for which no veteran is waiting. Hence, demand for residential care outstrips supply in most networks.

Table 5: Number of Substance Abuse Programs by Network

Network # Headquarters	Inpatient	Residential	Intensive OP	Standard OP
1 – Boston, MA	2	4	1	11
2 – Albany, NY	0	3	0	3
3 – Bronx, NY	0	5	3	5
4 – Pittsburgh, PA	0	6	1	6
5 – Baltimore, MD	0	2	1	2
6 – Durham, NC	1	4	1	3
7 – Atlanta, GA	1	0	4	3
8 – Bay Pines, FL	2	4	1	3
9 – Nashville, TN	1	1	1	3
10 – Cleveland, OH	1	2	1	5
11 – Ann Arbor, MI	1	1	2	4
12 – Hines, IL	0	7	1	6
15 – Kansas City, MO	0	1	5	3
16 – Jackson, MS	2	3	2	8
17 – Dallas, TX	0	2	1	0
18 – Phoenix, AZ	0	4	1	3
19 – Denver, CO	0	2	0	3
20 – Portland, OR	1	5	1	9
21 – San Francisco, CA	1	1	2	9
22 – Long Beach, CA	2	0	3	6
23 – Minneapolis, MN	0	7	5	3
Total	15	64	37	98

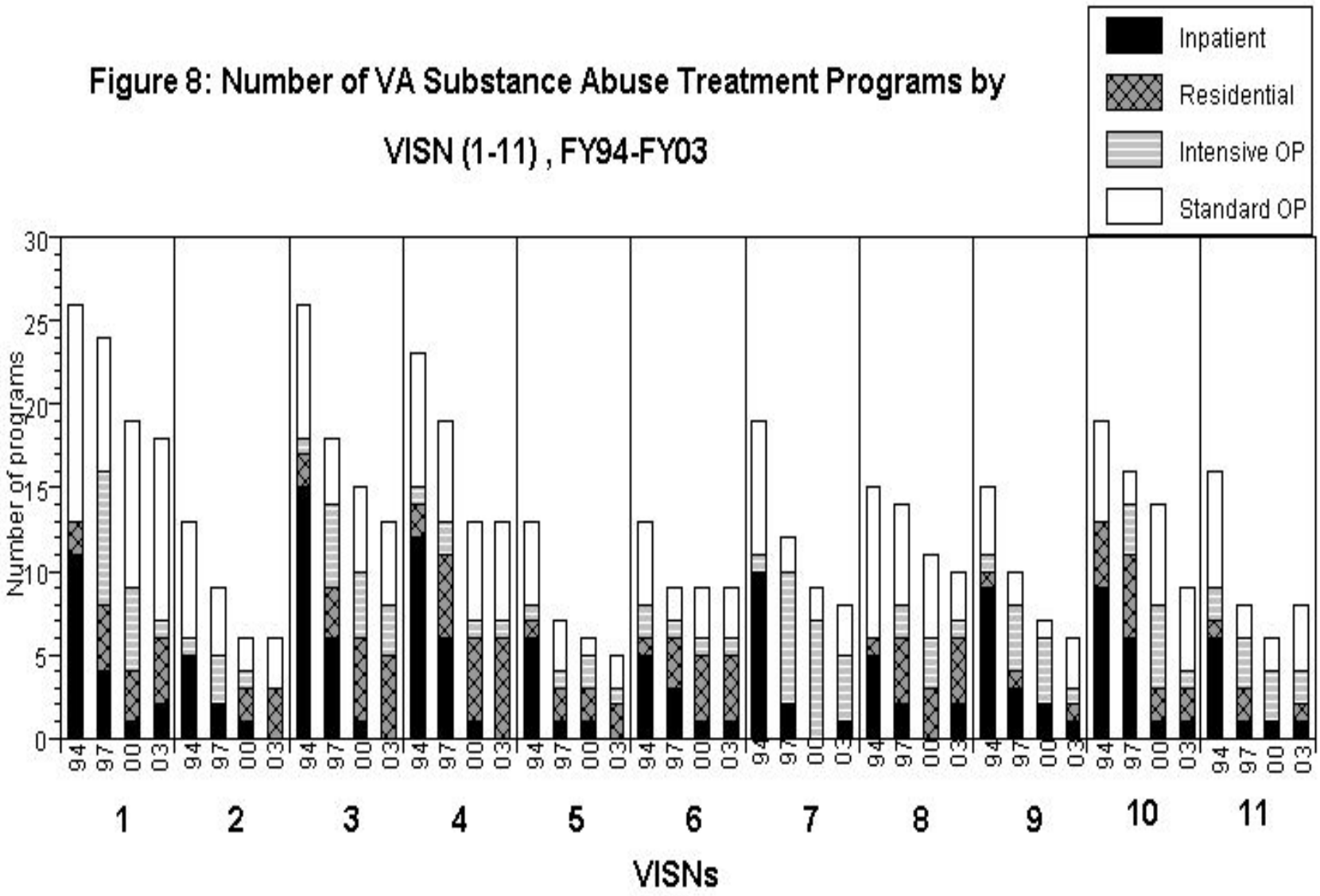


Figure 8: Number of VA Substance Abuse Treatment Programs by VISN (1-11) , FY94-FY03
Inpatient
Residential
Intensive OP
Standard OP
Number of programs
0
5
10
15
20
25
30
94
97
00
03
1
2
3
4
5
6
7
8
9
10
11
VISNs

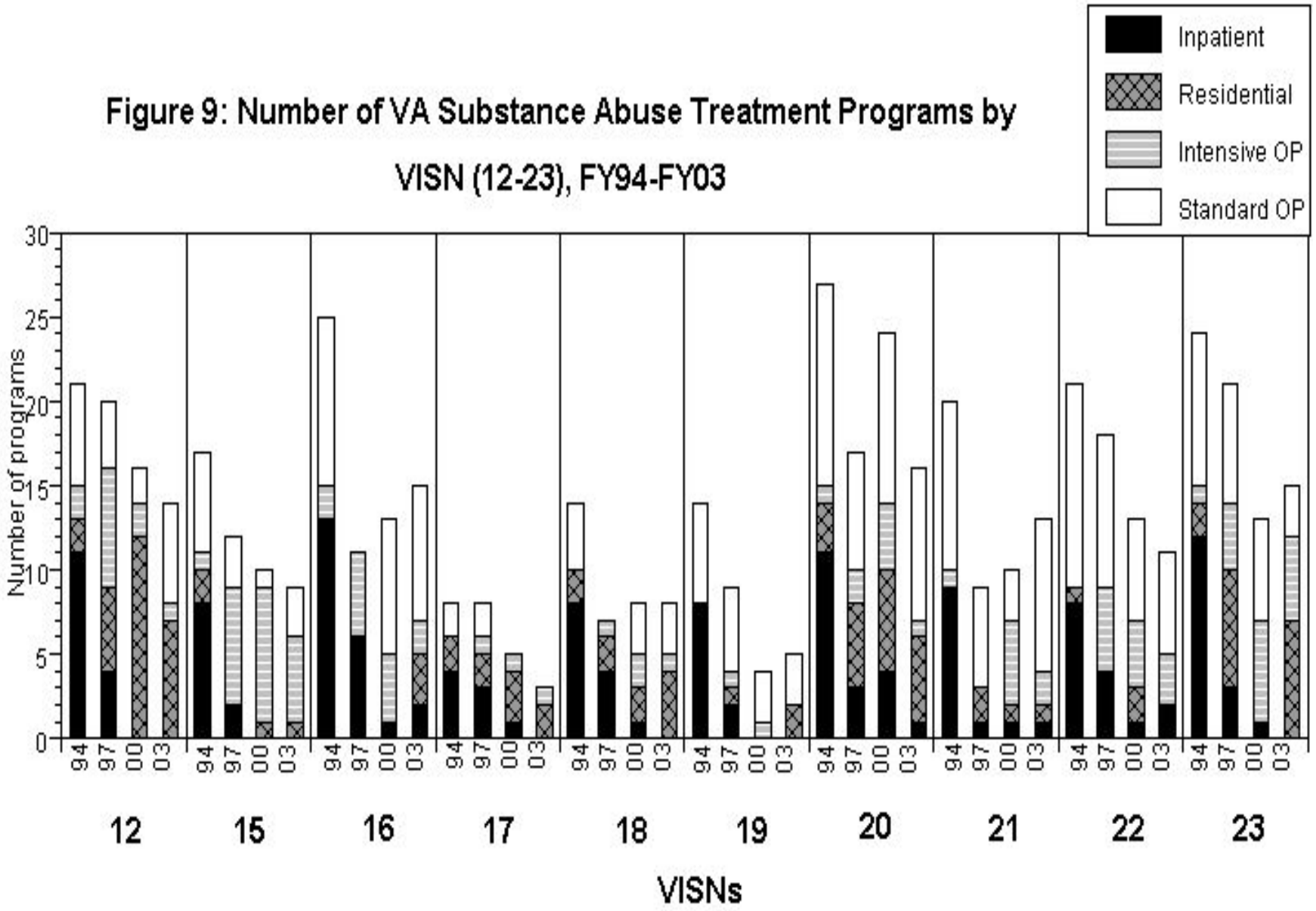


Figure 9: Number of VA Substance Abuse Treatment Programs by VISN (12-23), FY94-FY03
Inpatient
Residential
Intensive OP
Standard OP
Number of programs
0
5
10
15
20
25
30
94
97
00
03
12
15
16
17
18
19
20
21
22
23
VISNs

Table 6: Substance Abuse Beds and Waiting Lists by Network

	Inpatient			Residential		
Network # Headquarters	Beds	# Pts. Waitlist	% Waitlist of Capacity	Beds	# Pts. Waitlist	% Waitlist of Capacity
1 – Boston, MA	50	3	6%	95	33	35%
2 – Albany, NY	NA	NA	NA	252	0	0%
3 – Bronx, NY	NA	NA	NA	223	68	31%
4 – Pittsburgh, PA	NA	NA	NA	193	53	28%
5 – Baltimore, MD	NA	NA	NA	139	12	9%
6 – Durham, NC	20	0	0%	147	132	90%
7 – Atlanta, GA	6	37	617%	NA	NA	NA
8 – Bay Pines, FL	44	50	114%	76	50	66%
9 – Nashville, TN	19	0	0%	37	0	0%
10 – Cleveland, OH	70	0	0%	42	76	181%
11 – Ann Arbor, MI	18	176	978%	33	0	0%
12 – Hines, IL	NA	NA	NA	222	42	19%
15 – Kansas City, MO	NA	NA	NA	37	0	0%
16 – Jackson, MS	29	70	241%	48	55	115%
17 – Dallas, TX	NA	NA	NA	88	78	89%
18 – Phoenix, AZ	NA	NA	NA	182	48	26%
19 – Denver, CO	NA	NA	NA	25	8	32%
20 – Portland, OR	6	0	0%	254	35	14%
21 – San Francisco, CA	24	0	0%	30	13	43%
22 – Long Beach, CA	50	0	0%	NA	NA	NA
23 – Minneapolis, MN	NA	NA	NA	271	18	7%

Conclusions and Recommendations 2003

From FY00 to FY03, the VA substance abuse treatment system continued a contraction that began in FY95. Although standard outpatient programs expanded, all other forms of substance use disorder treatment decreased in availability. This contraction occurred despite additional funding from the Veterans Millennium Health Care and Benefits Act of 2000, which slowed but did not reverse declines in staff and programming. The continued reduction in inpatient and intensive outpatient programs results in a system that offers its patients less intensive treatment services then the former system. Further, VA substance abuse treatment programs are treating fewer patients and most programs in most networks have significant waiting lists, indicating reduced access to substance abuse treatment within VA. In summary, the availability of treatment programs for veterans seeking substance use disorder treatment in the VA system has declined to its lowest point since the FY94 DAPS.

1. Expand residential services and increase housing options for outpatients: The expansion in the number of residential treatment programs from FY94-FY00 was not continued from FY00-FY03. Residential programs offer a relatively inexpensive means of compensating for the continued loss of inpatient substance abuse beds. The reduction of beds for veterans with substance use disorders means that some veterans who are homeless or live great distances from VA facilities will not have the ability to easily participate in substance abuse treatment. Further, some veterans with substance use disorders have other co-morbidities that require more attention and treatment than can be provided on an ambulatory basis. Thus, an important goal for VA should be to expand residential programs and increase housing options for veterans with substance use disorders.

2. Continue to expand opioid agonist treatment services (OAT): The period from 2000 to 2003 brought significant changes to provision of OAT in the U.S.: (1) A black box warning about LAAM led to its discontinuation by its manufacturer in 2003, (2) Buprenorphine was approved for office-based OAT in 2002, (3) Regulations for methadone maintenance provision were modified in 2001 to accredit OAT clinics like other health care programs and ease restrictions on take-home dosing of long-term maintenance patients. Amid these transitions, the VA increased its capacity for providing OAT. Funding from the Veterans Millennium Health Care and Benefits Act of 2000 was used to open 4 new OAT clinics and expand 4 others, increasing the number of treatment slots at these 8 sites by 625 (PERC, 2003). OAT capacity increased at other VA substance use disorder treatment sites as well. Based on estimates from the DAPS, 10,628 patients received OAT from a VA substance use disorder treatment program in FY03, up from 6,013 in FY00. Yet, many eligible VA patients still do not receive this service.

Recent regulatory changes, the dissemination efforts of the QUERI Substance Abuse Module, and the approval of Subutex and Suboxone for office-based OAT have created an opportunity to dramatically expand availability of this treatment, which should literally prove life-saving (Barnett, 1999) for some opiate-dependent veterans. Encouraging VA physicians to complete SAMHSA training requirements for office-based OAT and VA pharmacies to add Subutex and Suboxone to their formularies would greatly increase the VA's capacity to offer

OAT in office-based settings. With the approval of medications allowing provision of office-based OAT, it is now possible to provide OAT to the many opiate dependent patients who do not live in proximity to one of the 38 licensed OAT clinics in the VA system, however, efforts to encourage adoption and use of this therapy are necessary. In the year after its approval, very few prescriptions of Subutex or Suboxone, all from a single VISN, were made in the VA. Efforts to increase use of office-based OAT and expand capacity at OAT clinics should be a high priority, particularly in cities with high prevalence of opiate use (e.g., Las Vegas, Phoenix, Tampa, Orlando, Salt Lake City).

3. Train staff to better link patients with community resources: The DAPS survey collects minimal data that directly measures the use of community resources, however it does gather information as to the percentage of patients that participate in on-site mutual-help groups. The apparent effectiveness of mutual-help groups (e.g., AA, NA) in alleviating SUD problems has been validated with increasingly rigorous empirical study (see Kelly, 2003). Yet in the average program, less than half of patients participated in on-site mutual-help groups in FY03. The continued contraction of treatment resources has increased the need for treatment providers to link patients to community resources. Few clinicians would disagree with the importance of linking patients to community resources, but many may not realize that concrete, empirically validated ways of doing so exist (e.g., Sisson & Mallams, 1981). Focused training in how to best link patients to mutual-help groups and other community resources might help make the VA more effective, both clinically and in terms of cost-effectiveness (Humphreys & Moos, 2001).

4. Encourage greater dissemination of underutilized evidence-based treatments: Despite empirical evidence supporting the long-term effectiveness of naltrexone for alcohol use disorders, nicotine replacement and buproprion for smoking cessation, and behavioral couples therapy for SUD patients with stable relationships (Trafton et al., 2004), the majority of patients with indications for these therapies do not receive them. These efficient and effective treatments for SUD should be utilized to their full potential.

5. Evaluate the impact of monies appropriated for VA substance use disorder services: The Veterans Millennium Health Care and Benefits Act of 2000 funded 31 proposals for expansion of substance use disorder treatment programs within the nationwide VA health care system. Overall implementation of the proposed expansion was successful. By the end of the initial funding period, 124.2 of the planned 137.75 FTE were hired, and funded programs reported significant increases in the number of patients treated. However, examination of the FY00 and FY03 DAPS data reveals that a substantial proportion of the gains in treatment capacity created by the Veterans Millennium Health Care and Benefits Act were offset by reductions in other substance use disorder programming at the funded stations. For example, although the Millennium Act funded 124.2 FTE, the net gain in FTEE over all funded stations was only 25.75 FTE. Although the number of outpatients treated at these stations increased by approximately 6000, the number of inpatients treated decreased by more than 1100 patients. Analysis of the DAPS data highlights the need to support the maintenance of currently available treatment services while funding expansions of new substance use disorder treatment services to produce significant gains in treatment capacity.

A new Congressional Act (PL. 108-170) allocated $25M for improvements in VA mental health care over the next three years, $5M of which will be devoted to substance use disorder services. Like the Veterans Millennium Health Care and Benefits Act of 2000, PL 108-170 represents another demonstration of Congressional interest and concern over the contraction of specialized substance use disorder services offered by VA. A lesson of recent years is that these funds will need to be carefully monitored to ensure that the new law expands substance use disorder treatment capacity.

Acknowledgments

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Notes

1 To the credit of VA program managers, the response rate for the FY03 DAPS was 99%. The response rate for the triennial DAPS surveys has averaged 99% since the process began in 1991. In the few cases where a program did not complete the DAPS for a given year, its data was imputed using mean values for other programs of the same type who completed the survey that year.

2 The total number of programs includes "case-finding and early intervention teams", which do not fit into the 4 main program types. Such programs identify and assess veterans who need substance abuse treatment (e.g., patients currently on a medical ward), provide brief transitional interventions, and refer patients to more intensive treatment as warranted. Case-finding teams first began to appear in the VA during FY94, and the first three are described in the PERC report on the DAPS for that year (Humphreys, Hamilton, & Moos, 1996). By FY97, five facilities had such teams, but this number had declined back to 1 by the FY03 DAPS.

3 In FY03, there was an overall decrease in the proportion of programs maintaining waiting lists. A brief phone survey of a subset of VA SUD programs suggested that this happened because waiting lists became impractically long, rather than because clinics were able to provide treatment on demand. The meaning of a lack of a waiting is thus hard to determine.

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A

Appendix A: The 2003 Drug and Alcohol Program Survey

2003 DRUG AND ALCOHOL PROGRAM SURVEY

This survey of VA substance abuse treatment programs is being conducted by the Program Evaluation and Resource Center (PERC) for the Mental Health Strategic Healthcare Group at Veterans Affairs Headquarters.
Please complete the survey and return it within two weeks.

All questions on this survey concern the program listed below. Please check the information on the attached label and make any necessary corrections:

Today's Date: _____

If someone other than the person listed above takes primary responsibility for responding to this survey, please enter his/her information below:

Respondent Name: _____

Job Title: _____

Telephone #: (_____) _____-_____ ext._____

Program Evaluation and Resource Center (152MPD)
VA Health Care System 795 Willow Road
Menlo Park, CA 94025
(650) 493-5000 ext. 22287
FAX: (650) 617-2736
stephen.tracy@med.va.gov

A. GENERAL PROGRAM AND PATIENT INFORMATION

1. Which category best describes your program? (CHECK ONE)

   Inpatient or Combined Inpatient and Outpatient……. ☐ 1

   Outpatient or Intensive Outpatient/Day Treatment……. ☐ 2

   Domiciliary…….. ☐ 3

   Residential Rehabilitation (includes CWT/TR/SARRTP/STAR)……... ☐ 4

   Case-finding and Early Intervention Team…….. ☐ 5

   Detoxification and Stabilization…….. ☐ 6

2. Is your program specifically intended to provide specialized services to substance abuse patients who have serious comorbid psychiatric disorders? No ☐ 0 Yes ☐ 1

If this program offers <u>outpatient services only</u>, skip to question 8.

3. How many operational beds did this program have as of September 30, 2003? _____ # of Beds

4. How many of this program's beds were occupied as of September 30, 2003? _____ # of Beds

5. What was this program's average occupancy rate during FY03? _____ % of Beds

6. What was the average length of stay for patients in this program in FY03, not counting time spent in outpatient/aftercare? _____ # of Days

7. How many unique patients were admitted to this program in FY03? (Patients admitted multiple times should be counted only once) _____ # of Patients

If your program offers <u>no outpatient services</u>, please skip to Question 12 on the next page.

8. How many unique patients received outpatient services in this program in FY03? (Patients admitted multiple times should be counted only once) _____ # of Patients

Questions 9-10 refer to how the OUTPATIENT services (including day hospital and intensive outpatient services) for this program are designed. If the treatment plans vary substantially across patients, please answer these items with reference to how treatment is planned for most of the patients in this program.

9. In the first week of outpatient treatment, on how many DAYS are patients supposed to receive services from this program? _____ # of Days

10. In the first week of outpatient treatment, how many HOURS per day are patients supposed to receive services from this program <u>on days that they receive treatment?</u> _____ # of Hours

11. Approximately what percentage of <u>outpatients</u> in your program stay overnight in the following types of housing when they are receiving outpatient services:

a. In private residences (including their own residence or that of a friend or relative) _____%

b. In on-site VA facilities (e.g., domiciliaries) _____%

c. In community-based facilities owned or contracted by the VA (e.g., halfway houses) _____%

d. In other community-based facilities (e.g., homeless shelters) **_____%**

ALL PROGRAMS OFFERING INTENSIVE INPATIENT (i.e., inpatient/residential for more than than 14 days) OR INTENSIVE OUTPATIENT (i.e., 3 or more hours per day for 3 or more days per week) TREATMENT SHOULD ANSWER QUESTIONS 12-13.

12. We are interested in practices your staff may use to encourage continuity of care for patients finishing intensive treatment and continuing in outpatient care (i.e., less than 3 hours per day, 3 days a week). Below is a list of continuity of care practices that staff may use. Please indicate how often in the past 3 months staff in the intensive treatment component of your program engaged in the following practices.

How often in the past 3 months did staff in the intensive treatment component of your program:	**Never/ rarely**	**Some-times**	**Fairly often**	**Almost Always**
a. Notify outpatient continuing care SUD counselors when patients who are being referred to them are discharged from intensive treatment?				
b. Meet with or contact outpatient continuing care SUD counselors at least once a month to review patients' progress and treatment?				
c. Speak directly (in person, by phone) with outpatient SUD counselors to review patients' discharge summary prior to their first appointement with their counselors?				
d. Work with outpatient continuing care SUD counselors to jointly develop discharge plans for patients?				
e. Contact outpatient continuing care SUD counselors within 14 days of patients' discharge from intensive treatment to check if patients are keeping continuing care substance abuse appointments?				

13. In the past 3 months, roughly what percent of patients in your program:

a. Had the same case manager or counselor during intensive treatment and continuing substance abuse care? _____ % of patients

b. Were assigned to the same counselor, case manager, or addictions treatment team if they relapsed and needed intensive SUD treatment again? _____ % of patients

ALL PROGRAMS SHOULD ANSWER THE FOLLOWING QUESTIONS

14. As of September 30, 2003, how many veterans were on this program's waiting list, including those waiting for a screening interview? (Indicate NA if this program does not maintain a waiting list) _____ # of Veterans

15. Approximately what percent of patients treated in this program in FY03 had the following characteristics at intake: Percent of patients (0-100)

    a. Were married or in a long-term, marriage-like relationship?……_____

    b. Were female?……_____

    c. Had an opioid dependence diagnosis?……_____

    d. Had both a substance abuse and a major psychiatric disorder?……_____

16a. Does your program usually base decisions about patients' treatment on clinical practice guidelines? IF NO SKIP TO ITEM 17. No ☐ 0 Yes ☐ 1

16b. Please indicate which practice guidelines this program uses (CHECK ALL THAT APPLY):

    a1. American Society of Addiction Medicine……☐ 1

    a2. American Psychiatric Association……☐ 1

    a3. Center for Substance Abuse Treatment……☐ 1

    a4. Department of Veterans Affairs……....☐ 1

    a5. Another set of guidelines (please specify)_____☐ 1

B. TREATMENT SERVICES

17. Below is a list of treatment services this program may provide. For each type of service indicate the estimated percentage of patients who receive this service directly from program staff (i.e., do not report services provided to your patients by other VA or non-VA programs). Where applicable, please also indicate the typical number of hours per week each activity is provided to each of those patients receiving that service.

Treatment Services	Percent of patients receiving this service from this program	Average number of hours per patient per week
a. Substance abuse-related self-help groups (e.g., AA, NA)		
b. Substance abuse-related group or individual psychotherapy		
c. Couples or family psychotherapy/counseling		
d. Psychological/Psychiatric assessment		
e. Group or individual therapy related to psychiatric problems		
f. Women specific groups or other services		
g. Vocational rehabilitation or work training		
h. Vocational/educational counseling		
i. Contingency contracting		NA
j. Medications for psychiatric problems (e.g., antidepressants, antipsychotics)		NA
k. Long-term opiate substitution maintenance treatment (e.g., LAAM, Methadone, Buprenorphine)		NA
l. Medication to aid detoxification from opiates (e.g., Clonidine)		NA
m. Medication to aid detoxification from alcohol (e.g., Benzodiazepines)		NA
n. Naltrexone for opioid use		NA
o. Naltrexone for alcoholism		NA
p. Smoking cessation aids (e.g., nicotine patch, gum, Wellbutrin)		NA
q. Hepatitis screening		NA

18. List any services that you would like to add to your program assuming you were provided the resources to do so:

_____

_____

C. CURRENT STAFF LISTING

19. Please list the total FTEE in this program for each job title as of October 1, 2003. Count only paid staff, not volunteers. Include those positions which are vacant if you are currently recruiting for them. If any of this program's positions are not listed, please include them under "All other staff" at the end of the list.

Position/Job Title	FTEE In this Program
a. Psychiatrist	
b. Physician (non-psychiatrist)	
c. Psychologist (Ph.D. or Psy.D.)	
d. Physician Assistant	
e. RN, Clinical Nurse Specialist, Nurse Practitioner	
f. LP Nurse, LV Nurse	
g. Nursing Assistant	
h. Social Worker (MSW, CSW, ACSW etc.)	
i. Addiction Therapist/Counselor (non-MSW)	
j. Psychology/Social Work/ Rehabilitation Tech or Aide	
k. Pharmacist	
l. Recreational Therapist	
m. Vocational Rehabilitation Specialist	
n. Secretary, Administrative Assistant, Clerk	
o. All other staff	
p. TOTAL FTEE IN THIS PROGRAM	

Thank you. You are finished. Please make a copy of the survey for your records and return the completed survey to PERC in the enclosed envelope or by fax.